

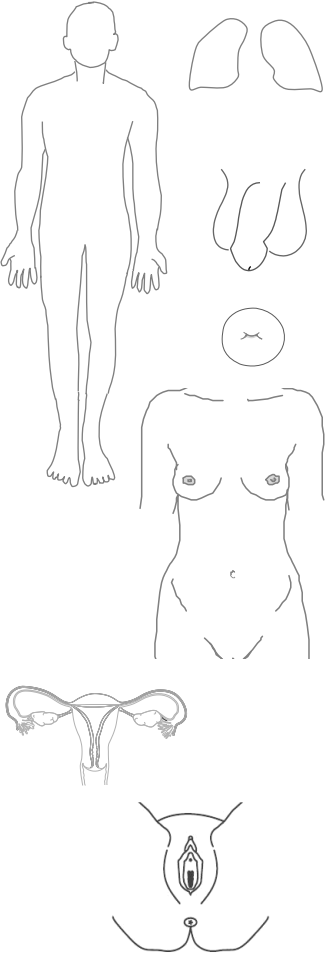
**ADULT INTERVAL HISTORY AND PHYSICAL**

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_\_ Family Doctor: \_\_\_\_\_ ☐ LEP: Interpreter \_\_\_\_\_

**Complete the following information:**

What is the main reason for your visit today?			
Are you having any problems or symptoms today that you would like to discuss? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, briefly explain:			
Are you allergic to any medicines or foods? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, list what medicines or foods you are allergic to and your reaction to each:			
Current medications ( <i>Prescription / Over the counter</i> ): <input type="checkbox"/> None <input type="checkbox"/> Multivitamins <input type="checkbox"/> Calcium <input type="checkbox"/> Birth Control _____ <input type="checkbox"/> Other:			
Since your last visit, have you had any hospitalizations, major injuries, or surgeries? <input type="checkbox"/> yes <input type="checkbox"/> no If you answered yes, briefly explain:			
Since your last visit, check if there have been major <b>health</b> changes for the following: <input type="checkbox"/> Patient (you) <input type="checkbox"/> Parent <input type="checkbox"/> Sister/ Brother <input type="checkbox"/> Child <input type="checkbox"/> Grandparent <input type="checkbox"/> None Describe any changes:			
Since your last visit, check if you have had major changes in the following: <input type="checkbox"/> Educational Status <input type="checkbox"/> Employment status <input type="checkbox"/> Marital status <input type="checkbox"/> Living conditions <input type="checkbox"/> None Describe any changes:			
<b>Nutrition: check foods you eat every day</b> <input type="checkbox"/> Milk / Dairy <input type="checkbox"/> Meats <input type="checkbox"/> Vegetables <input type="checkbox"/> Fruits <input type="checkbox"/> Breads or Grains		<b>Do you have concerns about your weight?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Tobacco Use / Smoke Exposure</b> <input type="checkbox"/> Never used <input type="checkbox"/> Exposed to smoke <input type="checkbox"/> Past user: type _____ <input type="checkbox"/> Use now: type _____ (# per day _____)		<b>Alcohol</b> <input type="checkbox"/> None <input type="checkbox"/> Seldom: type _____ <input type="checkbox"/> Occasional: type _____ <input type="checkbox"/> Frequent: type _____	
<b>Street Drugs</b> <input type="checkbox"/> None <input type="checkbox"/> Seldom: type _____ <input type="checkbox"/> Occasional: type _____ <input type="checkbox"/> Frequent: type _____		<b>Exercise</b> <input type="checkbox"/> None <input type="checkbox"/> Seldom <input type="checkbox"/> Occasional <input type="checkbox"/> Frequent	
<b>Dental Health</b> <input type="checkbox"/> Brush daily <input type="checkbox"/> Floss daily <input type="checkbox"/> Visit dentist every 6 months		<b>Water Source:</b> <input type="checkbox"/> Well <input type="checkbox"/> Cistern <input type="checkbox"/> Bottled <input type="checkbox"/> City	
<b>Abuse / Neglect / Violence:</b> <input type="checkbox"/> No fear of harm <input type="checkbox"/> Pressure to have sex <input type="checkbox"/> Daily needs not met <input type="checkbox"/> Forced sexual contact <input type="checkbox"/> Fear of verbal/physical abuse <input type="checkbox"/> Sex for money or drugs		<b>Mental Health: (in past 90 days)</b> <input type="checkbox"/> No Problem <input type="checkbox"/> Mild/Moderate Depression <input type="checkbox"/> Severe Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Thoughts of harming self / others	
<b>Sexually Active with:</b> <input type="checkbox"/> not sexually active <input type="checkbox"/> Males <input type="checkbox"/> Females <input type="checkbox"/> Both Number of partners: in past month _____ in past 2 months _____ in past 12 months _____		<b>Travel:</b> <input type="checkbox"/> No travel outside USA <input type="checkbox"/> Traveled outside USA: Country/Year _____/_____ <b>Females only:</b> Do you practice breast self-awareness (BSA)? <input type="checkbox"/> Yes <input type="checkbox"/> No First day of last menstrual period: _____/_____/_____	
<b>Reproductive Life Plan:</b> Do you have any children? <input type="checkbox"/> yes <input type="checkbox"/> no Do you want more children? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, how many more children do you want to have and when? _____			
Patient Signature: _____		Date: _____	
<b>TO BE COMPLETED BY HEALTHCARE PROVIDER</b>			
<b>Immunization Status:</b> <input type="checkbox"/> Up to date by patient report <input type="checkbox"/> Records requested <input type="checkbox"/> See Vaccine Administration Record <input type="checkbox"/> Vaccines given today		<b>Lead Assessment:</b> Verbal Risk Assessment: <input type="checkbox"/> neg <input type="checkbox"/> pos <input type="checkbox"/> NA Tested Today: <input type="checkbox"/> yes <input type="checkbox"/> no Referred for testing: <input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Health Education: topics discussed today</b> <div style="display: flex; flex-wrap: wrap;"> <div style="width: 33%;"> <input type="checkbox"/> Child development  <input type="checkbox"/> Immunizations  <input type="checkbox"/> Dental  <input type="checkbox"/> Hearing / Vision  <input type="checkbox"/> Lead exposure (ACH-25a)  <input type="checkbox"/> Diet / Nutrition           </div> <div style="width: 33%;"> <input type="checkbox"/> Physical activity  <input type="checkbox"/> Safety  <input type="checkbox"/> Mental Health  <input type="checkbox"/> DV / SA  <input type="checkbox"/> ATOD / Cessation / SHS  <input type="checkbox"/> Diabetes           </div> <div style="width: 33%;"> <input type="checkbox"/> Preconception / Folic Acid  <input type="checkbox"/> Prenatal / Genetics  <input type="checkbox"/> CVD  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Osteoporosis  <input type="checkbox"/> Cancer           </div> <div style="width: 33%;"> <input type="checkbox"/> Pelvic / Pap / HPV  <input type="checkbox"/> SBA/Mammogram  <input type="checkbox"/> STE/PSA  <input type="checkbox"/> HRT  <input type="checkbox"/> STD / HIV / HCV  <input type="checkbox"/> Family planning options  <input type="checkbox"/> Reproductive life plan           </div> </div>			<b>Educational Handouts:</b> <input type="checkbox"/> FPEM <input type="checkbox"/> PTEM <input type="checkbox"/> CSEM <input type="checkbox"/> Other: _____ <b>Patient Verbalizes Understanding of Education given</b> <input type="checkbox"/>
<input type="checkbox"/> MINOR Family Planning: <input type="checkbox"/> Sexual coercion. <input type="checkbox"/> Abstinence. <input type="checkbox"/> Benefits of parental involvement.			
Healthcare Provider Signature: _____		Date: _____	

**SUBJECTIVE / PRESENTING PROBLEM:****OBJECTIVE: General Multi-System Examination**

SYSTEM		WNL	ABNORMAL		SYSTEM		WNL	ABNORMAL
Constitutional	General appearance				Lymphatic	Neck, Axilla, Groin		
	Nutritional status				Musculoskeletal	Spine		
	Vital signs					ROM		
HEENT	Head: Fontanels, Scalp				Skin / SQ Tissue	Symmetry		
	Eyes: PERRL					Inspection (rashes)		
	Conjunctivae, lids				Palpation (nodules)			
	Ear: Canals, Drums				Neurological	Reflexes		
	Hearing					Sensation		
	Nose: Mucosa / Septum				Psychiatric	Orientation		
	Mouth: Lips, Palate					Mood / Affect		
	Teeth, Gums			<b>EXPLANATION OF ABNORMAL FINDINGS:</b>				
Throat: Tonsils								
Neck	Overall appearance							
	Thyroid							
Respiratory	Respiratory effort							
	Lungs							
Cardiovascular	Heart							
	Femoral / Pedal pulses							
	Extremities							
Chest	Thorax							
	Nipples							
	Breasts							
Gastro-intestinal	Abdomen							
	Liver / Spleen							
	Anus / Perineum							
Genitourinary	Male: Scrotum			<b>Tanner Stage:</b> <input type="checkbox"/> typical <input type="checkbox"/> atypical				
	Testes							
	Penis			<b>X-Ray: Type:</b> _____ <b>Result:</b> _____				
	Prostate			<b>Date taken:</b> _____ <input type="checkbox"/> No Change				
				<b>Date read:</b> _____ <input type="checkbox"/> Neg/Non-remarkable				
				<b>Date compared with:</b> _____ <input type="checkbox"/> Improved				
				<input type="checkbox"/> Worsening				
	Female: Genitalia			<b>TB Classification:</b> <input type="checkbox"/> TB suspect				
	Vagina			<input type="checkbox"/> 0 No TB exposure, not infected				
	Cervix			<input type="checkbox"/> I TB exposure, no evidence of infection				
Uterus			<input type="checkbox"/> II TB infection, without disease					
Adnexa			<input type="checkbox"/> III TB, clinically active					
			<input type="checkbox"/> IV TB, not clinically active					
			<b>Site of infection:</b> <input type="checkbox"/> Pulmonary <input type="checkbox"/> Cavity <input type="checkbox"/> Non Cavity <input type="checkbox"/> Other: _____					

**Sexually active minors:** Age of partner: \_\_\_\_\_**ASSESSMENT:****PLAN:**

<b>Testing today:</b> <input type="checkbox"/> N/A <input type="checkbox"/> GC / Chlamydia urine <input type="checkbox"/> GC / Chlamydia swab <input type="checkbox"/> UA <input type="checkbox"/> TST <input type="checkbox"/> VDRL <input type="checkbox"/> HIV <input type="checkbox"/> Hep C <input type="checkbox"/> Pap <input type="checkbox"/> Lead <input type="checkbox"/> HPV <input type="checkbox"/> Hgb <input type="checkbox"/> Cholesterol <input type="checkbox"/> Blood Glucose <input type="checkbox"/> Urine PT / UCG: <input type="checkbox"/> Pos <input type="checkbox"/> Neg Planned pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Wet Mount <input type="checkbox"/> Other: _____	<b>Medications/Supplies:</b> <input type="checkbox"/> N/A <input type="checkbox"/> MV / Folic Acid Number of bottles given _____ <input type="checkbox"/> Birth Control Method _____ <input type="checkbox"/> Given <input type="checkbox"/> Rx <input type="checkbox"/> Foam Issued (#) _____ <input type="checkbox"/> Condoms Issued (#) _____ <input type="checkbox"/> Foam/Condoms offered; pt. declined <input type="checkbox"/> Other: _____	<b>Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment:</b> <input type="checkbox"/> N/A <input type="checkbox"/> Vision <input type="checkbox"/> Hearing <input type="checkbox"/> FBS / GTT <input type="checkbox"/> Dental <input type="checkbox"/> Lipid Screen <input type="checkbox"/> Hgb <input type="checkbox"/> Pap Smear <input type="checkbox"/> Sickle Cell <input type="checkbox"/> Lead <input type="checkbox"/> Mammogram <input type="checkbox"/> Ultrasound <input type="checkbox"/> UCG/HCG <input type="checkbox"/> TST / CXR <input type="checkbox"/> Bone Density <input type="checkbox"/> Liver Panel <input type="checkbox"/> Blood Glucose <input type="checkbox"/> Colorectal Scr. <input type="checkbox"/> Ovarian Cancer Screen <input type="checkbox"/> Other: _____	<b>Referrals made:</b> <input type="checkbox"/> N/A <input type="checkbox"/> PCP / Medical Home <input type="checkbox"/> Pediatrician <input type="checkbox"/> WIC <input type="checkbox"/> FP <input type="checkbox"/> Medicaid <input type="checkbox"/> Radiology <input type="checkbox"/> HANDS <input type="checkbox"/> MNT with RD <input type="checkbox"/> Social Services <input type="checkbox"/> 1-800-QUIT-NOW <input type="checkbox"/> Freedom from Smoking <input type="checkbox"/> Specialist: <input type="checkbox"/> Other: _____
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**Healthcare Provider Signature:** \_\_\_\_\_**Date:** \_\_\_\_\_**Recommended RTC:** \_\_\_\_\_